



URGENT & FAMILY CARE

3200 SE 164th Ave. Suite 101
Vancouver, WA 98683
Phone # 360-882-6997
Fax # 360-882-4132

AUTHORIZATION TO RELEASE OF MEDICAL INFORMATION

PATIENT INFORMATION:

Patient Name: _____ Date of Birth: _____

Address: _____ Phone #: _____

RELEASE FROM:

Physician/Facility Name: _____ Phone #: _____

Address: _____ Fax #: _____

RELEASE TO:

INFORMATION REQUESTED:

- _____ Entire Record
- _____ Laboratory tests
- _____ X-Ray Films- MUST BE RETURNED (Hand Carried/Mailed)
- _____ Other _____

I understand that this information is for use by the recipient named above only. It cannot be given to any other individual or agency without my signed consent. This authorization will expire 90 days from the signature date and can be revoked by me at any time. I have a right to receive a copy of this authorization.

I understand that the information disclosed may contain matter that is protected by Federal and State laws, including information which may be related to ALCOHOL, DRUG, AND PSYCHIATRIC TREATMENT, AIDS AND/OR HIV TESTING AND/OR OTHER SEXUALLY TRANSMITTED DISEASES. I UNDERSTAND THIS INFORMATION WILL BE RELEASED UNLESS I SPECIFICALLY REQUEST THAT IT BE WITHHELD.

Signature of Patient or patient's authorized representative Date signed

Relationship if signed by anyone other than patient (parent, legal guardian, etc.)